

PROVIDER APPLICATION FOR BDDS AND WAIVER SERVICES

10/30/03

(Entity) Name:	
dba Name: (if applicable)	
Street Address:	Phone: ()
City/State/ZIP:	Fax: ()
	E-mail:
CEO/Admin.:	Contact Person:
FID# or SSN:	
Type of Entity (Check one):	
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership
<input type="checkbox"/> LLC	<input type="checkbox"/> Corp. for-profit
<input type="checkbox"/> Corp. non-profit	
PART 1. Services for individuals with <u>developmental disabilities</u>. (BDDS state funding, DD, Autism, & Support Services Waivers)	
Check all the services below to be considered for approval at this time.	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <u>Six (6) copies of written service proposal, application and specific documents required for these services. Complete Sections 1 A and 3 A.</u> </div> <div style="width: 45%;"> <u>Specific documents and application required for these services. (No written service proposal required.) Complete Sections 2 A and 3 A.</u> </div> </div>	
<input type="checkbox"/> Community-Based Sheltered Employment*	<input type="checkbox"/> Adult Day Services (Level: <input type="checkbox"/> 1, <input type="checkbox"/> 2, <input type="checkbox"/> 3) See pg. 5.
<input type="checkbox"/> Community Habilitation and Participation	<input type="checkbox"/> Applied Behavioral Analysis
<input type="checkbox"/> Crisis Assistance Services	<input type="checkbox"/> Behavioral Support Services
<input type="checkbox"/> Facility-Based Sheltered Employment *	<input type="checkbox"/> Case Management (waiver)
<input type="checkbox"/> Pre-Vocational Services	<input type="checkbox"/> Environmental Modifications (E-mods) See pg 5.
<input type="checkbox"/> Residential Habilitation and Support	<input type="checkbox"/> E-Mods Assessment, Inspection, and Training
<input type="checkbox"/> Residential Living Allowance Management	<input type="checkbox"/> Health Care Coordination
<input type="checkbox"/> Respite Care	<input type="checkbox"/> Music Therapy
<input type="checkbox"/> Supported Employment/Follow Along	<input type="checkbox"/> Nutritional Counseling
* Service reimbursed only through BDDS funding.	<input type="checkbox"/> Occupational Therapy
<u>Services automatically approved, when requested, only for a provider approved for Residential Habilitation.</u>	<input type="checkbox"/> Person Centered Planning Facilitation
	<input type="checkbox"/> Personal Emergency Response Systems
	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Adult Foster Care	<input type="checkbox"/> Psychological Therapy
<input type="checkbox"/> Community Transitional Services	<input type="checkbox"/> Recreational Therapy
<input type="checkbox"/> Independence Assistance Services	<input type="checkbox"/> Respite (Home Health Agency/individual) See pg .5.
<input type="checkbox"/> Rent/Food for Live-in, Unrelated Caregiver	<input type="checkbox"/> Specialized Medical Equipment/Supplies (SMES)
<input type="checkbox"/> Transportation - Residential Services	<input type="checkbox"/> SMES Assessment, Inspections and Training
	<input type="checkbox"/> Speech/Language Therapy
<u>Service automatically approved, when requested, only for providers approved for Community and/or Residential Habilitation.</u>	<input type="checkbox"/> Targeted Case Management - Diversional
	<input type="checkbox"/> Targeted Case Management - Deinstitutional
	<input type="checkbox"/> Transportation - Individual/Agency
<input type="checkbox"/> Community Educational/Therapeutic Activities	<input type="checkbox"/> Transportation - Title XX*
<input type="checkbox"/> Family & Caregiver Training	

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Part 2. Services for individuals with needs due to <u>age or physical disability</u>. (Aged & Disabled, Assisted Living, Medical Fragile Children, and TBI Waivers)	
Check all the services below to be considered for approval at this time.	
Application and specific documents required. Complete Sections 2 B and 3 B. KEY: ^ TBI Waiver Only ** See Additional Requirements on Page 5.	
<input type="checkbox"/> Adaptive Aids and Devices	<input type="checkbox"/> Physical Therapy ^
<input type="checkbox"/> Adult Day Services (Level: <input type="checkbox"/> 1, <input type="checkbox"/> 2, <input type="checkbox"/> 3)**	<input type="checkbox"/> Personal Emergency Response Systems
<input type="checkbox"/> Attendant Care**	<input type="checkbox"/> Residential Habilitation ^
<input type="checkbox"/> Assisted Living**	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Behavior Program/Counseling/Training ^	<input type="checkbox"/> Specialized Medical Equipment and Supplies
<input type="checkbox"/> Health Care Coordination ^	<input type="checkbox"/> Structured Day Program ^
<input type="checkbox"/> Home Delivered Meals**	<input type="checkbox"/> Speech/Hearing/Language Therapy
<input type="checkbox"/> Home/Environmental Modifications**	<input type="checkbox"/> Supported Employment ^
<input type="checkbox"/> Homemaker**	<input type="checkbox"/> Transportation ^
<input type="checkbox"/> Occupational Therapy ^	
SECTION 1A: Attach <u>6 copies</u> of information and written service proposal.	
1. Submit a limited criminal background check from the <u>Indiana State Police</u> obtained <u>within the last 90 days</u> for each individual involved in the management, administration, and provision of services in the agency to verify the individual has no history of crimes noted in 460 IAC 6-10-5.	
2. Submit documentation that the principle parties involved possess the managerial abilities of delivering requested services. 460 IAC 6-6-2 (3)	
3. Submit the documentation listed below per 460 IAC 6-11-2 and 6-11-3 to prove financial viability:	
A. Current financial status	
B. Credit history and the ability to obtain credit	
C. Current expenses and revenues	
D. Projected budgets outlining future operations (I.e., projected future costs and income)	
E. Statement of financial stability with the ability to deliver services without interruption for at least two (2) months without payment for services.	
4. If applying to provide the following services through a <u>state contract</u> , submit proof of not-for-profit status: Facility-based or Community-Based Sheltered Employment, Supported Employment Follow Along, Community Habilitation and Participation, Individual or Group Habilitation, Transportation - Title XX, Occupational, Speech, and/or Physical Therapy. (IC 12-11-1.1-3)	
5. Submit an organizational chart of agency, including parent and subsidiary corporations. 460 IAC 6-10-6.	
6. Submit evidence that the entity meets the qualifications for the specific services and supports for which the entity is seeking approval at this time. 460 IAC 6-5-1 and 6-14-3.	
7. Submit a staff training curriculum that complies with 460 IAC 6-14-4, and 6-16-3.	
8. Submit a policies and procedures manual that complies with 460 IAC 6-8-3 (5)(B); 6-9-2; 6-9-3 (b); 6-9-4 (c),(k), (m), (n), (o); 6-16-2 (a) (1), (b); 6-16-3; 6-18-3; 6-25-4 (d) (4), (7); and 6-29-5.	

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Section 1A: continued
9. Submit an operations manual that complies with 460 IAC 6-10-7(c), (d), (e); 6-10-10; 6-16-4; 6-25-4; 6-25-6; 6-25-7; 6-25-9.
10. Submit a written service proposal addressing programmatic issues for <u>each service</u> to be provided (per 460 IAC 6-6-2) . The proposal shall include:
A. Job descriptions for each position, including minimum qualifications for each position, major duties required of the position, responsibilities of the employee in the position, and the name/title of the supervisor to whom the employee in the position must report. 460 IAC 6-16-2 (b)(1) and 6-14-5.
B. Training given to staff specifically related to the service (training not all staff receive), if applicable. See specific service information in 460 IAC 460 6.
C. Policies and procedures that are specific to the delivery of the service, if not included elsewhere. See section 460 IAC 6-18-3.
D. Procedures for handling consumer's money, food stamps, living expenses and other assets (for situations where provider will assist with financial issues, bill-paying, etc.). 460 IAC 6-24-3.
E. An internal quality assurance and quality improvement system, including the evaluation mechanism to measure consumer satisfaction, including a copy of the form, an explanation of how frequently it will be distributed to individuals, and how the information will be utilized to enhance services. 460 IAC 6-10-10.
SECTION 2A: ATTACH ALL INFORMATION NOTED. (BDDS State funded, DD, Autism, and Support Services Waivers.)
1. Submit a limited criminal background check from the Indiana central repository for criminal history information for each individual involved in the management, administration, and provision of services in the agency to verify the individual has no history of crimes noted in 460 IAC 6-10-5.
2. Submit copies of licensure and/or other evidence required to document that the entity meets the qualifications for the specific services for which the entity is seeking approval. 460 IAC 6-5-1, 6-14-3.
SECTION 2 B: ATTACH ALL INFORMATION NOTED. (Aged & Disabled, Assisted Living, Medically Fragile Children, and TBI Waivers.)
1. Submit copies of licensure and/or other evidence required to document that the entity meets the qualifications for the specific services for which the entity is seeking approval, based on the waiver definitions and manuals.

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Section 3: Statements of Compliance	
<p><u>Section 3 A.</u> Statements in this section apply to <u>all providers of supported living services for individuals with developmental disabilities</u> . Check off the assurances before signing. Signature must be from an individual authorized to sign for the provider entity. <u>Unsigned/undated applications will be returned.</u></p>	
<p>___ 1. Provider assures that, if approved, the provider entity complies and will maintain compliance with all applicable state and federal statutes and regulations and licensure requirements of the approved service(s), including all applicable provisions of the federal Americans with Disabilities Act. IAC 6-10-3.</p>	
<p>___ 2. Provider assures that, if approved, the provider entity complies and will maintain compliance with 460 IAC 6, including documentation requirements for all providers and those related to the specific services the provider delivers.</p>	
<p>___ 3. Provider assures that, if approved, the provider will provide services to an individual as set out in the individual's Individualized Support Plan (ISP). 460 IAC 6-6-2 (5)</p>	
Signature:	
Name printed:	
Title:	Date:
<p>Mail to: MS 18, Program Review Committee, Bureau of Developmental Disabilities Services, P.O. Box 7083 Indianapolis, IN 46207</p>	
<p><u>Section 3 B.</u> Statements in this section apply only to providers of waiver services under the <u>Aged/Disabled, the Medically Fragile Children, the Traumatic Brain Injury, and the Assisted Living Waivers</u>. Check off the assurances before signing. Signature must be from an individual authorized to sign for the provider entity. Unsigned/undated applications will be returned.</p>	
<p>___ 1. Provider assures that, if approved, the provider entity complies and will maintain compliance with all applicable state and federal statutes regulations and licensure requirements for the approved service(s).</p>	
<p>___ 2. Provider assures that, if approved, the provider entity will provide only those Medicaid HCBS waiver services for which the provider has been approved, services which have been authorized by the recipients case manager or targeted case manager in the individual's Plan of Care/Cost Comparison Budget, and in accordance with the Waiver Provider Agreement.</p>	
Signature:	
Name printed:	Date:
Title:	

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Part 3: Services with Additional Requirements (See page 2)
The following services require additional information as indicated below. Please note that not all services are available on all waivers.
<u>Adult Day Services.</u> Requires an additional application specifically for these services.
<u>Assisted Living.</u> Requires an additional application for Assisted Living. * *
<u>Attendant Care -- Individual provider.</u> Requires proof of 1) successful completion of FSSA-approved training module or other applicable training (I.e., CNA certification, LPN, RN, or explanation of how attendant care has been provided in the past), 2) age, 3) current CPR certification, 4) negative TB test or chest x-ray within the last 30 days, 5) basic first aide course, 6) 2 letters of reference from individuals who are not family members, 7) criminal background check obtained from the Indiana State Police within the last 90 days
<u>Attendant Care - Agency Provider.</u> Requires proof that agency is a BDDS-approved agency providing services for individuals with developmental disabilities <u>or</u> a home health agency. A home health agency must also provide a copy of current licensure.
<u>Home Delivered Meals.</u> Requires an additional application for this service. *
<u>Home/Environmental Modifications.</u> Requires an additional application. Provider should also request the ADA Guidelines. *
<u>Homemaker - Individual Provider.</u> Requires evidence of 1) training appropriate to this service, 2) proof of age, 3) proof of negative TB test or chest x-ray within the last 30 days, 4) 2 letters of reference from individuals who are not relatives.
<u>Homemaker - Agency Provider.</u> Requires a copy of the agency's licensure as a home health agency and proof of liability insurance.
<u>Respite Care - Individual Provider.</u> Requires proof of 1) successful completion of FSSA-approved training module or other applicable training (I.e., CNA certification, LPN, RN, or explanation of how attendant care has been provided in the past), 2) age, 3) current CPR certification, 4) negative TB test or chest x-ray within the last 30 days, 5) basic first aide course, 6) 2 letters of reference from individuals who are not family members, 7) criminal background check obtained from the Indiana State Police within the last 90 days, 8) report from Nurse Aide Registry showing no complaints.
<u>Respite Care - Home Health Agency.</u> Submit licensure for agency, LPN, RN, Home Health Aide.
* For Additional Applications/ADA Guidelines -- Contact Robin Wilson at 317-232-7100.
** Application must be obtained from Willie Poindexter at (317) 232-7020